NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*
- Email correspondence between the editorial office and the authors*

*The corresponding author has opted to make this information publicly available.

Personal or nonessential information may be redacted at the editor’s discretion.

Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-18-2068

Incorporating pre-cesarean vaginal preparation into obstetrics’ standard of care

Dear Dr. Duffy:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the “track changes” feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Dec 21, 2018, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Thank you for the opportunity to review this excellent commentary recommending routine use of precesarean vaginal preparation during cesarean delivery.

Overall the commentary manuscript is thoughtfully organized, well-researched, well-written, and makes a compelling argument for the wider uptake of this low-risk intervention with promise to decrease postpartum maternal infection.

I have two suggestions that would modestly improve this commentary:

1) Is there any research about risks related to vaginal preparation? If so, these studies should be cited and if not, this might be recommended as an area for future research.

2) While women delivering by cesarean should not experience pain they will likely notice vaginal touch and pressure during pre-cesarean vaginal preparation. One would hope that adequate communication, preparation, and consent for this would be routinely incorporated with uptake of this proposed modification in US surgical practice as a matter of common sense, best practice, and respect. However, it may be wise to add a sentence or two discussing this aspect of clinical uptake.

Reviewer #2: This is a good review. It is clear, concise and well written. It is based on good science. If the premise of little use of the intervention is true, there is obvious need for its publication. There lies my one criticism of the manuscript. I was surprised by the stated lack of take up of vaginal preparation at Caesarean delivery and in particular caesarean delivery in labor with ruptured membranes. I wonder how robust their source is for establishing a lack of adoption of this technique. A survey of MFM fellows and inferred deductions from two papers may not accurately reflect the current state of affairs. I wonder about this as when we instituted this policy a few years ago, I surveyed local hospitals and found most were preparing or had such protocols in place. I understand publications such as Obstetrics & Gynecology may not support surveys, but given the context and potential importance of this review, a current quick two question survey (one for routine use, and one for in labor with ruptured membranes) would add to the paper significantly.
Reviewer #3:

Overall: This paper makes a compelling argument regarding the efficacy and importance of preoperative vaginal preparation in high-risk women, and the need for wider-scale implementation of this measure in standard obstetric practice.

1. Title and Precis: The title and precis are clearly written and effectively summarize the main supposition of the paper.

2. Abstract: Concisely summarizes the main argument. Introduces the secondary argument that preoperative vaginal preparation is as effective as the addition of azithromycin prophylaxis. Thus, vaginal preparation should be recommended for implementation as standard of care, as azithromycin prophylaxis has been.

3. Primary Argument: Preoperative vaginal preparation reduces infectious morbidity in high-risk women undergoing cesarean delivery in a manner similar to and as efficacious as azithromycin prophylaxis. However, implementation of this measure remains poor. Preoperative vaginal preparation should be added to the standard of obstetric care just as azithromycin prophylaxis has been.

4. Supporting Evidence/Arguments:
   a. Several meta-analyses, including a growing body of recent data, support the efficacy of vaginal preparation in reducing postoperative infectious morbidity in high-risk women. This evidence is presented in a clear and convincing manner.
   b. Uptake of preoperative vaginal preparation has been poor, and this practice is not yet standard of care. This is supported by recent survey data and by a secondary analysis of the CSOAP trial. Lastly, the authors provide evidence that even when an institutional protocol is in place, implantation is not yet universal. In lines 103-105, the argument is not strengthened by restating the recommendation of a previously mentioned meta-analysis.
   c. Preoperative vaginal preparation is efficacious as azithromycin prophylaxis in reducing certain infectious morbidity in high-risk women, and likely has a similar mechanism of action. Evidence provided is sufficient. However, clarification for why azithromycin has been more accepted into practice would strengthen & further clarify this part of the secondary argument.
   d. Vaginal preparation offers advantages over azithromycin prophylaxis. Data to support or further develop this idea would strengthen this argument.
   e. While further research is still needed to elucidate best practices, implantation of preoperative vaginal preparation should not be delayed while further questions are answered. This argument is well-developed and you make a strong case.

5. Recommendations: Preoperative vaginal preparation should be performed prior to all cesarean deliveries performed after the onset of labor or rupture of membranes. A strong argument is made and adequate supporting evidence is provided throughout the paper to support this recommendation.

Reviewer #4: The current commentary is within the 12 page limit but does exceed 12 references limitation. Overall the topic is reasonable. I am unclear why vaginal prep prior to cesarean delivery isn't more widely practiced - I did check and this appears to be the practice at our institution. From a quality perspective the commentary does much to identify the issue but there isn't much said about how to fix the problem. The excess references largely "beat a dead horse" but understanding why this practice isn't more widely used would seemingly be the most interesting and actionable aspect to the matter. I've never understood entirely how Betadine works as a vaginal prep insofar as the mantra has always been that Betadine is not a contact disinfectant (it's a "dessicant" is what I'm told). Baby shampoo has been used with good effect as a vaginal prep hence perhaps the mechanism of action has less to do with the cleanser and more to do with the vehicle dilution of the bacteria? In any case, if this commentary gets a few hospitals to re-examine their policies around cesarean delivery preparation that would be good.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 128-129: "independence" has a specific statistical meaning, such that if each intervention reduced infection rates by ~ 50%, then their concomitant use would reduce infections by ~ 75%. Is there a reference that supports the independent effect of these interventions?

lines 126-128 seem to imply a common mechanism for the two interventions.

Alternatively, effects could be additive, but overlap, or synergistic. Should cite studies that evaluate the effects of both interventions vs each separately to establish independence of the interventions.
EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor’s specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript.

***The notated PDF is uploaded to this submission’s record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - rzung@greenjournal.org.***

- would you consider putting the direct impacts on women first in this list?

- please clarify that the 1/2 reduction is on top of the use of other interventions used--that its not a stand alone intervention. Its compelling that even with the other interventions it works this well.

- worth commenting that one should avoid alcohol containing preps due to discomfort?

2. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
   1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
   2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

3. Each author on this manuscript must submit a completed copy of our revised author agreement form (updated in the January 2018 issue). Please note:

   a) Any material included in your submission that is not original or that you are not able to transfer copyright for must be listed under I.B on the first page of the author agreement form.

   b) All authors must disclose any financial involvement that could represent potential conflicts of interest in an attachment to the author agreement form.

   c) All authors must indicate their contributions to the submission by checking the applicable boxes on the author agreement form.

   d) The role of authorship in Obstetrics & Gynecology is reserved for those individuals who meet the criteria recommended by the International Committee of Medical Journal Editors (ICMJE; http://www.icmje.org):

      * Substantial contributions to the conception or design of the work;
      OR
      the acquisition, analysis, or interpretation of data for the work;
      AND
      * Drafting the work or revising it critically for important intellectual content;
      AND
      * Final approval of the version to be published;
      AND
      * Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

The author agreement form is available online at http://edmgr.ovid.com/ong/accounts/agreementform.pdf. Signed forms should be scanned and uploaded into Editorial Manager with your other manuscript files. Any forms collected after your revision is submitted may be e-mailed to obgyn@greenjournal.org.

4. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at http://links.lww.com/AOG/A515, and the gynecology data definitions are available at http://links.lww.com/AOG/A935.

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendixes).
6. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Current Commentary articles, 250 words. Please provide a word count.

7. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

8. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

9. The American College of Obstetricians and Gynecologists' (College) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite College documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly. If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if a College document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All College documents (eg, Committee Opinions and Practice Bulletins) may be found via the Resources and Publications page at http://www.acog.org/Resources-And-Publications.

10. If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at http://ong.editorialmanager.com. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors, that each author has given approval to the final form of the revision, and that the agreement form signed by each author and submitted with the initial version remains valid.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Dec 21, 2018, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.
December 17, 2018

Dear Editors,

Please consider this revision of “Incorporating pre-cesarean vaginal preparation into obstetrics’ standard of care” for publication as a Current Commentary in Obstetrics & Gynecology. All reviewer comments are copied and addressed below with responses in italics.

As lead author, I affirm that all authors have approved the revised manuscript and agree with its resubmission to Obstetrics & Gynecology. This manuscript has not been published elsewhere and is not under consideration by another journal. Finally, I also affirm that all authors have no conflicts of interest or relevant financial disclosures.

REVIEWER COMMENTS

Reviewer #1: Thank you for the opportunity to review this excellent commentary recommending routine use of pre-cesarean vaginal preparation during cesarean delivery.

Overall the commentary manuscript is thoughtfully organized, well-researched, well-written, and makes a compelling argument for the wider uptake of this low-risk intervention with promise to decrease postpartum maternal infection.

I have two suggestions that would modestly improve this commentary:

1) Is there any research about risks related to vaginal preparation? If so, these studies should be cited and if not, this might be recommended as an area for future research.

Thank you for this question. We agree this is an important concern regarding vaginal preparation. In the Cochrane review from 2018, which includes over 3,000 women, there were no adverse events reported. Please see lines 96-98 that addresses this concern.

2) While women delivering by cesarean should not experience pain they will likely notice vaginal touch and pressure during pre-cesarean vaginal preparation. One would hope that adequate communication, preparation, and consent for this would be routinely incorporated with uptake of this proposed modification in US surgical practice as a matter of common sense, best practice, and respect. However, it may be wise to add a sentence or two discussing this aspect of clinical uptake.

Thank you for this comment. We have added a brief discussion of this, please see lines 178-181.
Reviewer #2: This is a good review. It is clear, concise and well written. It is based on good science. If the premise of little use of the intervention is true, there is obvious need for its publication. There lies my one criticism of the manuscript. I was surprised by the stated lack of take up of vaginal preparation at caesarean delivery and in particular caesarean delivery in labor with ruptured membranes. I wonder how robust their source is for establishing a lack of adoption of this technique. A survey of MFM fellows and inferred deductions from two papers may not accurately reflect the current state of affairs. I wonder about this as when we instituted this policy a few years ago, I surveyed local hospitals and found most were preparing or had such protocols in place. I understand publications such as Obstetrics & Gynecology may not support surveys, but given the context and potential importance of this review, a current quick two question survey (one for routine use, and one for in labor with ruptured membranes) would add to the paper significantly.

Thank you for these comments. We agree that the evidence for lack of uptake of pre-cesarean vaginal preparation is probably less compelling than the evidence for its benefit. We are reassured to hear that many hospitals have protocols for this, but we also know there are still large centers that have not adopted this practice and others that are struggling to improve compliance with new policies and protocols for vaginal preparation. Given the evidence reviewed here, our hope is that this commentary will help providers to uniformly adopt this practice. We agree that a simple survey on this matter might lend support to the argument but feel that this is beyond the scope of the commentary.

We have also added references to ACOG guidelines for vaginal preparation before gynecologic surgery and cesarean to further support our argument (See lines and 128-129 and 173-178.)

Reviewer #3:

Overall: This paper makes a compelling argument regarding the efficacy and importance of preoperative vaginal preparation in high-risk women, and the need for wider-scale implementation of this measure in standard obstetric practice.

1. Title and Precis: The title and precis are clearly written and effectively summarize the main supposition of the paper.

2. Abstract: Concisely summarizes the main argument. Introduces the secondary argument that preoperative vaginal preparation is as effective as the addition of azithromycin prophylaxis. Thus, vaginal preparation should be recommended for implementation as standard of care, as azithromycin prophylaxis has been.

3. Primary Argument: Preoperative vaginal preparation reduces infectious morbidity in high-risk women undergoing cesarean delivery in a manner similar to and as efficacious as azithromycin prophylaxis. However, implementation of this measure remains poor. Preoperative vaginal preparation should be added to the standard of obstetric care just as azithromycin prophylaxis has been.

4. Supporting Evidence/Arguments:
   a. Several meta-analyses, including a growing body of recent data, support the efficacy of vaginal preparation in reducing postoperative infectious morbidity in high-risk women. This evidence is presented in a clear and convincing manner.

   b. Uptake of preoperative vaginal preparation has been poor, and this practice is not yet standard of
care. This is supported by recent survey data and by a secondary analysis of the CSOAP trial. Lastly, the authors provide evidence that even when an institutional protocol is in place, implementation is not yet universal. In lines 103-105, the argument is not strengthened by restating the recommendation of a previously mentioned meta-analysis.

Thank you for this comment. We agree with the reviewer that this may be the weakest argument for the lack of uptake of vaginal preparation of those discussed. However due to the limited evidence (as highlighted by Reviewer #2) we feel that a recent publication in this high-impact journal that concludes that vaginal preparation should be performed for high-risk women does suggest that it is not yet standard of care.

c. Preoperative vaginal preparation is efficacious as azithromycin prophylaxis in reducing certain infectious morbidity in high-risk women, and likely has a similar mechanism of action. Evidence provided is sufficient. However, clarification for why azithromycin has been more accepted into practice would strengthen & further clarify this part of the secondary argument.

Thank you for this comment. We do not feel there is enough supporting evidence at this time to state that azithromycin use is employed more commonly than vaginal preparation.

d. Vaginal preparation offers advantages over azithromycin prophylaxis. Data to support or further develop this idea would strengthen this argument.

Thank you for this suggestion. However, we do not want to suggest that vaginal preparation be used instead of azithromycin as there may be a cumulative or synergistic effect to these interventions (please see lines 159-162).

e. While further research is still needed to elucidate best practices, implantation of preoperative vaginal preparation should not be delayed while further questions are answered. This argument is well-developed and you make a strong case.

5. Recommendations: Preoperative vaginal preparation should be performed prior to all cesarean deliveries performed after the onset of labor or rupture of membranes. A strong argument is made and adequate supporting evidence is provided throughout the paper to support this recommendation.

Thank you for all the above comments.

Reviewer #4: The current commentary is within the 12 page limit but does exceed 12 references limitation. Overall the topic is reasonable. I am unclear why vaginal prep prior to cesarean delivery isn't more widely practiced - I did check and this appears to be the practice at our institution. From a quality perspective the commentary does much to identify the issue but there isn't much said about how to fix the problem. The excess references largely "beat a dead horse" but understanding why this practice isn't more widely used would seemingly be the most interesting and actionable aspect to the matter. I've never understood entirely how Betadine works as a vaginal prep insofar as the mantra has always been that Betadine is not a contact disinfectant (its a "dessicant" is what I'm told). Baby shampoo has been used with good effect as a vaginal prep hence perhaps the mechanism of action has less to do with the cleanser and more to do with the vehicle dilution of the bacteria? In any case, if this commentary gets a few hospitals to re-examine their policies around cesarean delivery preparation that would be good.
Thank you very much for these comments. We agree that the evidence for vaginal preparation is overwhelming, but felt it important to include all the recent, large meta-analyses. We feel that their similar conclusions lend further weight to the argument for this very simple intervention. We are also hopeful that this commentary could help change practice and improve implementation of vaginal preparation.

We acknowledge that our number of references exceeds the 12 reference limit, but felt these were all important to the discussion. Two references have been removed from the original draft and three have been added to this revision. If the editors would like us to limit the total references to 12, we would be happy to do so.

We agree that the reason why vaginal preparation is not more widely practiced is an interesting one, and we have added a brief discussion of this (lines 171-181).

STATISTICAL EDITOR COMMENTS

The Statistical Editor makes the following points that need to be addressed:

lines 128-129: “independence” has a specific statistical meaning, such that if each intervention reduced infection rates by ~ 50%, then their concomitant use would reduce infections by ~ 75%. Is there a reference that supports the independent effect of these interventions?

Thank you. “Independently” was not meant to be used as such. To our knowledge there are no studies that support a clear independent effect of these interventions. That sentence has been revised to clarify this and “independence” has been removed.

lines 126-128 seem to imply a common mechanism for the two interventions.

Yes, this is not proven, but we propose that they might share a common mechanism.

Alternatively, effects could be additive, but overlap, or synergistic. Should cite studies that evaluate the effects of both interventions vs each separately to establish independence of the interventions.

Thank you for this comment. Unfortunately to our knowledge, such studies do not exist. The existing studies cited herein were not properly designed to address this question. This lack of knowledge is further addressed in lines 161-162.

EDITOR COMMENTS

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor’s specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript.

- would you consider putting the direct impacts on women first in this list?

Thank you for this suggestion. The order of the consequences of endometritis has been revised (lines 56-58) to highlight the impacts on women.
- please clarify that the 1/2 reduction is on top of the use of other interventions used--that its not a stand alone intervention. Its compelling that even with the other interventions it works this well.

*Thank you for this comment. This statement has been revised (lines 79-81) to clarify this important point.*

- worth commenting that one should avoid alcohol containing preps due to discomfort?

*Thank you for this suggestion. We agree this is a very important point especially regarding chlorhexidine preparation, which may prove to be a superior vaginal antiseptic. We have expanded on this and revised lines 191-200 to this effect.*

Thank you very much for your review of this commentary and for considering this revision. Please do not hesitate to contact me with any questions.

Sincerely,

Cassandra Duffy  
Maternal Fetal Medicine clinical fellow  
Department of Obstetrics and Gynecology  
Columbia University Medical Center
Dear Randi,

Thank you so much. Here are responses to your inquiries below. The revision is attached with tracked changes.

1. General: The Editor has made edits to the manuscript using track changes. Please review them to make sure they are correct.

All looks good. Thank you.

2. Electronic Copyright Transfer Agreements: Dr. Gyamfi-Bannerman and Dr. Goldenberg still need to complete their eCTA forms online.

I reached out to Dr. Gyamfi regarding the eCTA this morning and she says she will look into it today.

3. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript’s lead author. The statement is as follows: “The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.” *The manuscript’s guarantor.

Please provide a signed version of this statement. A blank copy of this statement is at Previously submitted.

4. Line 103: Although not the focus of your paper, would you consider listing these 4 specific techniques? (Always worth reinforcing them).

The four surgical techniques were added as requested. Thank you for this suggestion.

5. Line 184-186: Reference 25 is no longer a current document. I will find out from ACOG’s Resource Center if there is current guidance that would support this statement.

Reference #25 (ACOG CO 571) was replaced with #17 (PB 195, already cited). Thank you for your help with this.

The only other change was the addition of a middle initial in the author line.

Please let me know if you need anything else.

Thank you,

Cassandra
From: Randi Zung <RZung@greenjournal.org>
Sent: Thursday, December 27, 2018 10:06:34 AM
To: Duffy, Cassandra R.
Subject: RE: Your Revised Manuscript 18-2068R1

Dear Dr. Duffy:

You may send the next version of your manuscript back to me by email.

Dr. Goldenberg has completed his eCTA form. We are still waiting to hear back from Dr. Gyamfi.

Your eCTA form information was captured when you submitted the revision. The questions that appeared in Editorial Manager when you were uploading the new files are “the form.”

Thanks,
Randi

From: Duffy, Cassandra R.
Sent: Friday, December 21, 2018 10:26 AM
To: Randi Zung <RZung@greenjournal.org>
Subject: Re: Your Revised Manuscript 18-2068R1

Dear Randi Zung,

Thank you for the all the feedback. I had a few questions.

1) When I finish the edits, should I resubmit by attaching the document in an email to you? Or do I use the online Editorial Manager?

2) Have Dr. Goldenberg and Dr. Gyamfi completed their eCTA forms yet?

3) I do not believe I received a link to complete an eCTA form myself, do I need to do this?

Attached is my signed transparency statement.

Thank you so much,
Cassandra
Dear Dr. Duffy:

Your revised manuscript is being reviewed by the Editors. Before a final decision can be made, we need you to address the following queries. Please make the requested changes to the latest version of your manuscript that is attached to this email. Please track your changes and leave the ones made by the Editorial Office. Please also note your responses to the author queries in your email message back to me.

1. General: The Editor has made edits to the manuscript using track changes. Please review them to make sure they are correct.

2. Electronic Copyright Transfer Agreements: Dr. Gyamfi-Bannerman and Dr. Goldenberg still need to complete their eCTA forms online.

3. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript’s lead author. The statement is as follows: “The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.” *The manuscript’s guarantor.

   Please provide a signed version of this statement. A blank copy of this statement is at

4. Line 103: Although not the focus of your paper, would you consider listing these 4 specific techniques? (Always worth reinforcing them).

5. Line 184-186: Reference 25 is no longer a current document. I will find out from ACOG’s Resource Center if there is current guidance that would support this statement.

To facilitate the review process, we would appreciate receiving a response by December 28.

Best,
Randi Zung